

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029587

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 642

FILED AUG 7 1963

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		c. CITY OR TOWN Woodland Park	
Length of stay in 1b 1 day		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hospital		d. STREET ADDRESS Box 310 (If outside, give location) #6 Woodland Park	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELEANOR ELIZABETH REITZ		4. DATE OF DEATH Month August Day 3 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-17-1899
9. AGE (last birthday) 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (City and state or country) Marissa, Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Henry Hocker		13b. MOTHER'S MAIDEN NAME Elizabeth Heinecke	
14. NAME OF HUSBAND OR WIFE CONRAD REITZ, deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No None		16. SOCIAL SECURITY NO. Mr. George H. Reitz, 10406 Niblic Dr.	
17. INFORMANT Mr. George H. Reitz, 10406 Niblic Dr.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heat Stroke		INTERVAL BETWEEN ONSET AND DEATH 12 Hr.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Marissa, Illinois	
21. I attended the deceased from Aug 2, 1963 to Aug 3, 1963 and last saw her alive on Aug 3, 1963 Death occurred at 5:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W.A. Poggenmeyer MD (Degree or title)		22b. ADDRESS St Charles, MO	
22c. DATE SIGNED Aug 3, 1963 (State)			
23a. BURIAL OR CREMATION REMOVAL (Specify) via MOTOR	23b. DATE August 7, 1963	23c. NAME OF CEMETERY OR CREMATORY Marissa, Cemetery	23d. LOCATION (City, town, or county) Marissa, Illinois
24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Bl.		25. DATE RECD. BY LOCAL REG. Aug 5-1963	
26. REGISTRAR'S SIGNATURE Mabel Zamwalt Dep			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

1 0928

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9 9319

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11 130

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13 50

Dr. Poggemeier
2nd & Clay, St. Charles, Mo.
(Over Pharmacy)
RA 4-6336

Hours till Noon Saturday

AUG 13 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

for by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John A. Mlinar

Licensed Embalmer No. 4186

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.